DD-405-PF (10-05)

Clear The Form

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

NURSING ASSESSMENT HEALTH CARE SERVICES

DATE

CLIENT'S NAME *(Last, First, M.I.)* | BIRTHDATE | ASSISTS ID NO.

CLIENTS ADDRESS *(No., Street, City, State, ZIP)* | PHONE NO.

RESPONSIBLE PERSON'S NAME | RELATIONSHIP

CASE MANAGER'S NAME | UNIT | PHONE NO.

DIAGNOSIS

1.	2.	3.
4.	5.	6.

ALLERGIES

Yes	No	
☐	☐	Health Care Directive
☐	☐	Court Order Health Care Directive
☐	☐	ALTCS: _____ *Name of Health Plan*
☐	☐	AHCCCS *(Acute Care/non-ALTCS)*: _____ *Name of Health Plan*
☐	☐	CRS: Eligible Condition(s): _____
☐	☐	Other Insurance: _____ *Name of Company* Home Nursing covered: ☐ Yes ☐ No

Group No.: _____ Policy No.: _____ Phone No.: _____

Historian:

PART I – ASSESSMENT OF NURSING SERVICE

1. APPROPRIATENESS OF NURSING SERVICE

- ☐ Needs total or near total assistance to carry out essential required care activities.
- ☐ Essential care take an extraordinary amount of the caregiver's time as compared to a non-disabled individual of comparable age.
- ☐ Essential care requires professional training of caregivers.
- ☐ Nursing required.
- ☐ Home health aide.
- ☐ No nursing required.

NURSING ISPP OBJECTIVE

2. AMOUNT/FREQUENCY OF SKILLED NURSING

SUN	MON	TUES	WED	THUR	FRI	SAT

This will be coordinated with the support coordinator and transferred onto the Daily Care Plan Schedule.

- ☐ Skilled nursing. Number of hours per month: _____
- ☐ Intermittent visits. Number of hours per month: _____
- ☐ Nursing respite. Number of hours per month: _____
- ☐ Home health aide. Number of hours per month: _____
- ☐ Home health aide for respite. Number of hours per month: _____

Nurses Initials _____

CLIENT'S NAME *(Last, First, M.I.)*

3. CAREGIVER SKILLS REQUIRED

GASTROINTESTINAL CARE:

- ☐ Nasal gastric tube insertion and feedings.
- ☐ Replacement of jejuno tube.

BOWEL CARE:

- ☐ Ostomy & stomal enemas and irrigations.

GENITO URINARY CARE:

- ☐ Urinary catheter replacement.
- ☐ Intermittent urinary catheterization.
- ☐ Nephrostomy site care and tube replacement.
- ☐ In-home dialysis.

NEUROLOGICAL CARE:

- ☐ Ventricular shunt monitoring. *(unstable/complex)*
- ☐ Seizure monitoring. *(unstable/complex)*

RESPIRATORY CARE:

Respiratory Treatments:

- ☐ Respiratory treatment, including SVN with chest percussion and postural drainage with deep oral/nasal suctioning.
- ☐ Oxygen administration and associated equipment.
- ☐ Monitoring respiratory status/mechanical monitoring *(i.e., pulse oximeter, apnea monitor)*

Tracheostomy:

- ☐ Tracheostomy care including stomal cleaning and tie changing.
- ☐ Replacement of tracheostomy tube.
- ☐ Tracheostomy culture and sensitivity.
- ☐ Deep suctioning.
- ☐ Ventilation *(Six hours or greater per day and 30-days continuous. Consult Ventilator Program Manager.)*
- ☐ Intermittent C-pap or Bi-pap without rate.
- ☐ C-pap or Bi-pap dependent.

IV THERAPY:

☐ Central line: ☐ Inactive ☐ Active ☐ Portacath ☐ Other:

INJECTIONS

WOUND CARE

4. ASSESSMENT OF HOME ENVIRONMENT *(Optional)*

Yes	No	
☐	☐	Safety concerns *(if yes, identify)*:
☐	☐	Caregiver needs training *(if yes, specify)*:

PROBLEMS/RECOMMENDATIONS

Nurses Initials _____

CLIENT'S NAME *(Last, First, M.I.)*

PART II – MEDICAL HISTORY

PRIMARY CARE PHYSICIAN'S NAME	PHONE NO.

Complete if client is under the care of specialists.

TYPE OF SPECIALIST	DOCTOR'S NAME	PHONE NO.
☐ Gastroenterologist		
☐ Orthopedist		
☐ Neurologist		
☐ Pulmonologist		
☐ Otolaryngologist (ENT)		
☐ Ophthalmologist		
☐ General Surgeon		
☐ Cardiologist		
☐ Neurosurgeon		
☐ Endocrinologist		
☐ Geneticist		
☐ Psychiatrist		
☐ Other:		

DATE OF LAST VISIT TO PHYSICIAN	DATE OF LAST PHYSICAL/EPSDT	DATE OF LAST VISIT TO DENTIST

CONCERNS/COMMENTS

1. VISUAL IMPAIRMENT *(If yes, explain)*	DATE OF LAST EXAM	EYE GLASSES
☐ Yes ☐ No		☐ Yes ☐ No
2. AUDIO IMPAIRMENT *(If yes, explain)*	DATE OF LAST EXAM	HEARING AIDS
☐ Yes ☐ No		☐ Yes ☐ No

FUNCTIONAL LIMITATIONS

☐ Ambulatory ☐ Non-ambulatory ☐ Bed Rest ☐ Hoyer Lift ☐ Non-verbal
☐ Total Lift ☐ Wheelchair ☐ Sign language/communication device ☐ Other:

4. SEIZURES	CURRENT	PAST	CONTROLLED
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

SPECIAL PROCEDURES

5. BLADDER CONTROL	HX UTIs *(History of urinary tract infections)*	REQUIRES CATHETERIZATION
☐ Continent ☐ Incontinent	☐ Yes ☐ No	☐ Yes ☐ No
6. BOWEL CONTROL	BOWEL CARE OF CHOICE	
☐ Continent ☐ Incontinent	☐ Yes ☐ No	

7. NUTRITION

Current Weight _____ Current Height _____

Yes	No	
☐	☐	HX FTT *(If yes, last nutrition evaluation)*: _____
☐	☐	Special diet *(If yes, explain)*: _____
☐	☐	Special feeding needs *(If yes, explain)*: _____
		Feeding: ☐ NG ☐ G ☐ J Formula supplier: _____
		☐ Yes ☐ No Bolus *(If yes, frequency)*: _____
		☐ Yes ☐ No Pump *(If yes, frequency)*: _____
		☐ Yes ☐ No Stoma care *(If yes, type/frequency)*: _____
		☐ Yes ☐ No Recent weight gain/loss *(If yes, previous weight)*: _____
		☐ Yes ☐ No WIC

Nurses Initials _____

CLIENT'S NAME *(Last, First, M.I.)*

8. MEDICATIONS *(List all medications and include IV and oxygen)*

NAME OF MEDICATION	**PURPOSE**	**DOSAGE**	**ROUTE**

Are immunizations current? ☐ Yes ☐ No

Nurses Initials ______________

CLIENT'S NAME *(Last, First, M.I.)*

9. BEHAVIOR

Yes ☐ No ☐ Concerns *(If yes, explain)*: _____

Yes ☐ No ☐ Interventions *(If yes, explain):* _____

Mental Status:

☐ Alert ☐ Agitated ☐ Unable to follow directions

☐ Confused ☐ Cooperative ☐ Other:

10. THERAPY

Yes ☐ No ☐ Speech therapy *(If yes, frequency)*: _____

Yes ☐ No ☐ Occupational therapy *(If yes, frequency)*: _____

Yes ☐ No ☐ Physical therapy *(If yes, frequency)*: _____

Yes ☐ No ☐ Other therapy need?

11. HOSPITALIZATIONS - **PAST YEAR** ☐ None

DATE	REASON	DATE	REASON

VISITS TO ER – **PAST YEAR** ☐ None

DATE	REASON	DATE	REASON

12. SURGERIES – **PAST YEAR** ☐ None

DATE	REASON	DATE	REASON

SURGERIES – **PRIOR TO PAST YEAR** ☐ None

DATE	REASON	DATE	REASON

CLIENT'S NAME *(Last, First, M.I.)*

DME SUPPLIER

13. EQUIPMENT

☐ Aerosol or oxygen mist	☐ Central Line	☐ Hospital bed	☐ Pulse oximeter	☐ Trach
☐ Ambu bag	☐ CPAP/BIPAP	☐ IPPB	☐ Room Monitor *(non-medical)*	☐ Vent
☐ Apnea monitor	☐ Feeding pump	☐ IV pump	☐ Suction	☐ Wheelchair
☐ Bathroom aids	☐ GT/GB	☐ Oxygen	☐ SVN	☐ Other:

14. RESPIRATORY CARE

Yes	No		
☐	☐	SVN *(If yes, frequency)*:	
☐	☐	CPT *(If yes, frequency)*:	
☐	☐	Suction *(If yes, frequency)*:	Type:
☐	☐	Oxygen *(If yes, amount)*:	Frequency:
☐	☐	Aerosol *(If yes, amount)*:	
☐	☐	Pulse oximeter *(If yes, frequency)*:	
		Special concerns:	
		Trach type:	Size:
		Trach change frequency:	
		Trach tie change frequency:	
☐	☐	Stoma care *(If yes, frequency):*	

15. SKIN INTEGRITY

16. CONCERNS/COMMENTS *(Include present and potential problems, problem areas requiring further investigation and psychosocial concerns)*

Nurses Initials _____

CLIENT'S NAME *(Last, First, M.I.)*

CONCERNS/COMMENTS

Nurses Initials _____

CLIENT'S NAME *(Last, First, M.I.)*

PART III – DAILY SKILLED CARE PLAN SCHEDULE	
07:00 A.M.	
08:00 A.M.	
09:00 A.M.	
10:00 A.M.	
11:00 A.M.	
12:00 Noon	
01:00 P.M.	
02:00 P.M.	
03:00 P.M.	
04:00 P.M.	
05:00 P.M.	
06:00 P.M.	
07:00 P.M.	
08:00 P.M.	
09:00 P.M.	
10:00 P.M.	
11:00 P.M.	
12:00 Mid.	
01:00 A.M.	
02:00 A.M.	
03:00 A.M.	
04:00 A.M.	
05:00 A.M.	
06:00 A.M.	

INTERMITTENT/PRN SKILLED NEEDS

DDD NURSE'S SIGNATURE	DATE